AHCCCS Is Arizona's Medical Assistance Program (Medicaid)

AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Disability Report

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and Social Security number in the space provided and answer all questions. **COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.**

PRIVACY ACT NOTICE: The information requested on this form is authorized by Title 20 CFR 404.1512 and Title 20 CFR 416.912. The information provided will be used in making a decision on your claim. While completion of this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of some benefits. Information you furnish on this form may be disclosed by the Social Security Administration to another person or government agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and another agency.

Name of claimant	Social Security Number
Telephone number where claimant can be reached (include area code)	Best time to reach claimant

What is the disabling condition? (Briefly explain the injury or illness that stops you from working).

PART I – INFORMATION ABOUT YOUR CONDITION

1. When did your condition first bother you?	Month	Day	Year
2a. Did you work after the date shown in item 1? (If NO, go to items 3A and 3B).	❑ YES		❑ NO
2b. If you did work since the date in item 1, did your condition cause you to change -			
Your job or job duties?	❑ YES		❑ NO
Your hours of work?	❑ YES		❑ NO
Your attendance?	❑ YES		❑ NO
Anything else about your work?	❑ YES		❑ NO
If you answered NO to <u>ALL</u> of these, go to items 3a and 3b.			

2c. If you answered YES to **<u>any</u>** item in 2b, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary.

3a. When did your condition finally make you stop working?	Month	Day	Year

3b. Explain how your condition now keeps you from working.

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

4. List the name, address, and telephone number of the doctor who has your latest medical records about your disabling condition below:

❑ Check here if you have no doctor

Name	Address
Telephone Number (including area code)	

How often do you see this doctor?	Date you first saw this doctor (mo/day/yr)	Date you last saw this doctor (mo/day/yr)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, show "NONE".

5a. Have you seen any other doctor(s) since your disabling condition began? ❑ YES ❑ NO If YES, show the following:

Name	Address
Telephone Number (including area code)	

How often do you see this doctor?	Date you first saw this doctor (mo/day/yr)	Date you last saw this doctor (mo/day/yr)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, show "NONE".

5b. Identify below any other doctor you have seen since your illness or injury began.

Name	Address
Telephone Number (including area code)	

How often do you see this doctor?	Date you first saw this doctor (mo/day/yr)	Date you last saw this doctor (mo/day/yr)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, show "NONE".

If you have seen other doctors since your disabling condition began, list their names, addresses, dates and reasons for visits in Part VI.

6. Have you been hospitalized or treated at a clinic for your disabling condition? ❑ YES ❑ NO
If YES, show the following:

Name of Hospital or Clinic		Address
Patient or Clinic Number		
Were you an inpatient (i.e. stayed at least overnight)? ❑ YES ❑ NO If YES, show the following:		Were you an outpatient? ❑ YES ❑ NO If YES, show the following:
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

Reason for Hospitalization or Clinic Visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, show "NONE".

6b. If you have been in another hospital or clinic for your illness or injury, identify it below.

Name of Hospital or Clinic		Address
Patient or Clinic Number		
Were you an inpatient (i.e. stayed at least overnight)? ❑ YES ❑ NO If YES, fill in the dates below:		Were you an outpatient? ❑ YES ❑ NO If YES, fill in the dates below:
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

Reason for Hospitalization or Clinic Visits (show illness or injury for which you had an examination or treatment.)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, show "NONE".

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.

7. Have you been seen by other agencies for your disabling condition? (VA, worker's compensation, welfare, etc.). ❑ YES ❑ NO If YES, fill in the information below:

Name of Agency	Agency Address
Your Claim Number	
Dates of Visits (mo./day, year)	Types of treatments or examination received

If more space is needed, list the other agencies, their address, your claim numbers, dates, and treatment received in Part VI.

8. Have you had any of the following tests in the last year?

TEST	YES/NO	If YES, show Where Done	If YES, show When Done
Electrocardiogram	❑ YES ❑ NO		
Chest X-ray	❑ YES ❑ NO		
Other X-ray (name body part here)	❑ YES ❑ NO		
Breathing Tests	❑ YES ❑ NO		
Blood Tests	❑ YES ❑ NO		
Other (specify)	❑ YES ❑ NO		
Other (specify)	❑ YES ❑ NO		

9. If you have a Medicaid card, what is your number (some hospitals and clinics file your records by your Medicaid number).

PART III – INFORMATION ABOUT YOUR ACTIVITIES

10. Has any doctor told you to cut back or limit your activities in any way? ❑ YES ❑ NO If YES, give the name of the doctor below and tell what he/she told you about cutting back or limiting your activities.

11. Describe your daily activities and state what and how much you do of each, how often you do it, and any assistance you require.

- **HOUSEHOLD MAINTENANCE** (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

- **RECREATIONAL ACTIVITIES AND HOBBIES** (hunting, fishing, bowling, hiking, musical instruments, etc):

- **SOCIAL CONTACTS** (visits with friends, relatives, neighbors):

- **OTHER** (drive car, motorcycle, ride bus, etc):

PART IV – INFORMATION ABOUT YOUR EDUCATION

12. What is the highest grade of school that you completed?	Month/Year Completed?

13. Have you gone to trade or vocational school or had any type of special training? ❑ YES ❑ NO
If YES, show:

- The type of trade or vocational school or training:
- Approximate dates you attended:
- How this schooling or training was used in any work you did.

PART V – INFORMATION ABOUT THE WORK YOU DID

14 List all jobs you have had in the last 15 years before you stopped working, beginning with your usual job. Normally, this will be the kind of work you did the longest. (If you have a 6th grade education or less, AND did only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began to work.) If you need more space, use Part VI or attach a separate piece of paper.

Job Title (be sure to begin with your usual job)	Type of Business	Dates Worked (Month/Year)		Days Per Week	Rate of Pay (per hour, day, week, month or year)
		FROM	TO		

15a. Provide the following information for your usual job shown in item 14, line 1.
In your job did you:

- Use machines, tools, or equipment of any kind? ❑ YES ❑ NO
- Use technical knowledge or skills? ❑ YES ❑ NO
- Do any writing, complete reports, or perform similar duties? ❑ YES ❑ NO
- Have supervisory responsibilities? ❑ YES ❑ NO

15b. Describe your basic duties (explain what you did and how you did it) below. Also, explain all YES answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision.

15c. Described the kind and amount of physical activity this job involved during a typical day in terms of:

- **WALKING** (circle the number of hours a day spent walking) 0 1 2 3 4 5 6 7 8
- **STANDING** (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7 8
- **SITTING** (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8
- **BENDING** (circle how often a day you had to bend) Never Occasionally Frequently Constantly
- **REACHING** (circle how often a day you had to reach) Never Occasionally Frequently Constantly
- **LIFTING AND CARRYING:** Describe below what was lifted, and how far it was carried. Check heaviest weight lifted below and weight frequently lifted and/or carried:

HEAVIEST WEIGHT LIFTED	WEIGHT FREQUENTLY LIFTED/CARRIED
❑ 10 lbs. ❑ 20 lbs. ❑ 50 lbs. ❑ 100 lbs. ❑ Over 100 lbs.	❑ Up to 10 lbs. ❑ Up to 20 lbs. ❑ Up to 50 lbs. ❑ Over 50 lbs.

PART VI – REMARKS/CLAIMANT INFORMATION

Use this section to answer any previous questions or to give any additional information that you think will be helpful in making a decision in your disability claim. Please refer to the previous items by number. If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.

Does the claimant speak English? ❑ YES ❑ NO If NO, what language does the claimant speak?

Does the claimant need assistance in processing his/her claim? ❑ YES ❑ NO If YES, enter the name, address, phone number and relationship of person providing assistance to the claimant. Also, show why claimant requires assistance (foreign speaking, unable to ambulate, etc.)

Name of person providing assistance	Relationship of person providing assistance
Address of person providing assistance	
Telephone number of person providing assistance (including area code)	Best time to reach person providing assistance
Reason the claimant requires assistance	

PART VII – AUTHORIZATION AND NOTIFICATION STATEMENTS

I declare under penalty of perjury under the laws of the State of Arizona that the information on this form is true and correct to the best of my knowledge. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionaire is applicable to all claims.

- Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Services Administration.
- The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
- I agree to notify the AHCCCS Administration if my condition improves or I go to work.
- I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law. I affirm that the above statements are true.

Name (Signature of claimant or person filing on the claimant's behalf)	Date (mo/day/yr)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (number and street, city, state, and zip code)	Address (number and street, city, state, and zip code)

PART VIII – FOR AHCCCS USE ONLY – DO NOT WRITE BELOW THIS LINE

DE-121 Taken by: ❑ Personal Interview ❑ Telephone ❑ Mail	Form Supplemented ❑ YES ❑ NO If YES, by: ❑ Personal Interview ❑ Telephone ❑ Mail

Signature of Eligibility Specialist	Date (mo/day/yr)
Local Office Address	Local Office Phone Number